A Description of the Prior Authorization System Requested to this Point

There have now been four JAD sessions covering phase one of the MRSIS system design. The JAD team members have worked thoughtfully and diligently, and most of what the team is requesting of Harmony is now known. It remains to be seen how Harmony can configure MRSIS to achieve the requested system.

Phase one of MRSIS configuration consists of building a prior authorization system that will replace the contracting methodology the Division has used in the past. In order to make the prior authorization system work efficiently, MRSIS has to contain a billing component whereby contracting providers will bill MRSIS rather than EDS. MRSIS will adjudicate the claims against the prior authorizations and pass the claims on to EDS unchanged. Finally, MRSIS configuration in the first phase includes designing a remittance system that will incorporate the state payments with the federal payments, making allowance for local match payments already made to the contractors.

These elements--prior authorization, billing and claims processing, and remittance, will be described in this brief, reflecting the design decisions made to date.

Prior Authorization

The prior authorization will consist of information from the Medicaid Plan of Care as created by the treatment team and submitted by the case manager. The regional office will process the plan of care to create the prior authorization in two segments. One segment will run from the projected start date to the end of August. The second segment will run from the first of September to the end of the year covered by the person's plan. There will be two prior authorization numbers, and billing for services within a segment will require the use of the associated prior authorization number.

How many units of each service are entered into each segment will depend on the frequency of service delivery specified on the plan of care. MRSIS will project the appropriate number of units within each segment from the planned frequency (for example, 5 days a week, or daily, or twice per month). MRSIS will also incorporate a projected absentee rate (percentage) that the provider will be asked to provide for two services: day habilitation and residential habilitation. Residential habilitation already has an absentee projection in the IRBI and this projection will be used in the prior authorization. Day habilitation absentee rates will need to be submitted separately, and in ensuing years, may be calculated per individual from prior years billings.

The intent of using the absentee rates is to mitigate the effect of moving from the current payment of one-twelfth per month to blended payment of federal and match in one check. As the last month of an authorization approaches, the regional office will run a standard report comparing units billed to units encumbered. Units left unused by one person will be unencumbered and placed in a pool to assign to persons using more than authorized units. The pool will be specific to each provider with the stipulation that the region, and

the Division, will move units to fill gaps, so long as the original provider is able to bill all provided units.

A funding code will be assigned to each service in the prior authorization specifying from which source the match should be taken. The intention is to assign consumers to either state or local funding sources, but the design will incorporate the flexibility to set some consumers up with “hybrid” match sources. With this flexibility, a person may have one service matched by state and another service matched by local funds, within the same authorization. There will also be the option for one person to have one service matched by state funds for a specific period of time and by local funds for a different period of time. And finally, a single service may be authorized for both state and local match for the same period of time, if need be, but this will require separate authorizations. The operation of the MR Community Services Account will be built into MRSIS but will continue to work the same way; local match donated directly to the account will be registered and processed so that payment reaches the intended provider as quickly as possible.

The intent of creating the flexibility described above is to let providers transition gradually to the point where specific people are assigned entirely to one match source or the other. This system has to rely on local match for several millions of dollars each year, and the Division will work with each provider to ensure that he or she is not penalized for using this match. Some providers may never be able to transition to the desired point – the MRSIS system will remain flexible as long as it is needed. A caveat about local match: while services can be authorized based on the expectation of match being available, claims cannot be paid unless the necessary local match has reached the MR Community Services Account and been registered.

Changes in service mix or level of service for an individual can be processed by modifying the plan of care, which, with Regional Office approval, will drive a change in the prior authorization. Services can be added to, increased, decreased, or deleted from the prior authorization in real time by the Regional Office. Currently such changes require a change in the plan of care and, if they involve additional funding from the State, a contract amendment. With MRSIS, the service modification will require a change in plan of care, and, if it involves additional funding from either the State or Medicaid, will require the plan of care to be sent to the Regional Office which, rather than issuing a contract amendment, will change the prior authorization. Changes in IRBI rates that are approved by the Regional Office will be added to the prior authorization as of a specific date of service; the first rate will be terminated and a new rate, and new span of service, will be authorized within the same authorization.

Billing and Claims Processing

Providers will be able to track their authorizations in Two-Part Harmony, both in the individual and aggregate modes. Providers will also be able to bill MRSIS with Two-Part Harmony, but they can also bill in other ways, most notably by submitting a HIPAA compliant 837 transaction to MRSIS. Claims will be received by MRSIS and adjudicated

within 24 hours, with a report back to the submitting providers so they can see what, if anything, has failed the MRSIS edits, as well as what has passed the edits. These edits are being set up to mirror the most common errors providers encounter in currently billing EDS, because the goal is to send EDS the fewest possible claims that will fail. It is intended that providers will be able to correct and re-submit the MRSIS-rejected claims without having to re-key them.

In addition, it should be noted that MRSIS will not change a provider's billing. Rates for Residential Habilitation, Environmental Accessibility Adaptations and Assistive Technology will be set for the individual in the prior authorization. We still need to see what flexibility Medicaid will let us have with individual rates for Specialized Medical Equipment and Supplies. For all other services the rates are set in Medicaid and EDS. Claims for the individually priced services will edit against the rate in the prior authorization, and if they don't match the prior authorized rate they will be sent back to the provider and not be forwarded to EDS until the rate is corrected. All claims for services with rates set in EDS will be forwarded to EDS unchanged. EDS will adjust those claims as needed. The submitting provider will know from his remittance advice what denials and/or adjustments were made, and where in the system they were made.

Remittance

After claims have been adjudicated and approved by MRSIS, they are sent to EDS on a timetable. EDS will adjudicate all the claims and transmit its results back to MRSIS in the standard EOP (835) format and timetable. MRSIS will post the paid claims and create the necessary vouchers for the Department Finance Office to request the warrants. It is not completely worked out as to when the final remittance advice will be sent to the Two-Part Harmony users and the 835 to 837 submitters, but the report will be electronic and will come sooner than the current "green bar" paper report. It is intended to provide a report that will show the provider what was paid and what was denied, and to total funds paid by whether they were Federal, State, or Local (pre-paid).

The level and accuracy of the information returned to the submitting provider will assure a clean audit trail for the provider. In addition, it will greatly improve the audit trail at all levels, if and when CMS asks for information. Assuming that the submitting provider sends correct information and has documentation that the services billed were actually provided, paying 100% of the claim is as secure as a Medicaid payment system can get. When debiting the local match account and paying only the federal share, being able to account for local match expenditure on a claim-by-claim basis is nearly as secure.